BROOKHAVEN SCIENCE ASSOCIATES MEDICAL PLAN COMPARISON FOR EMPLOYEES IN IBEW UNION

	CIGNA Preferred Provider Option (PPO)		Aetna (HMO)	Vytra (HMO)	HIP (HMO)
	In-Network	**Out-of-Network**			
Medical Care Provider	Participating physician/facility	Any physician/facility	Participating physician/facility	Participating physician/facility	Participating physician/facility
Payment of Benefits	No claim forms	Submit claim forms	No claim forms	No claim forms	No claim forms
Age Limit for Dependent Children/Full-Time Student	To age 19/ End of the year age 23	To age 19/ End of the year age 23	End of the month age 19/End of the year age 23	To age 19/End of the year age 23	End of the month age 19/End of the year age 23
Annual Deductible (Individual/Family)	N/A	$250/$650	N/A	N/A	N/A
Annual Out-of-Pocket Maximum (Individual/Family) (Excluding Deductible)	N/A	$1200/$2400	$1500/$3000	N/A	N/A
Lifetime Maximum Benefit	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Pre-Existing Condition Limitation	N/A	N/A	N/A	N/A	N/A
Office Visits	Covered in full after $10 co-pay	80% of R&C after deductible	Covered in full after $5 co-pay	Covered in full after $5 co-pay	Covered in full
Emergency Room (Accident)	Covered in full	Emergency: Covered in full Non-emergency: 80% of	Covered in full after $35 co-pay (waived if admitted)	Covered in full after $25 co-pay (waived if admitted)	Covered in full after $50 co-pay (waived if admitted)
(Illness)	Covered in full	R&C after deductible			
Inpatient Hospital					
(Semi-Private Room, Board, Services, Supplies)	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full
	Pre-admission certification required or $250 penalty plus 50% reduction in benefits on any days not approved.				
(Physician)	Covered in full	80% of R&C after deductible	Covered in full	Covered in full	Covered in full
(Surgeon)	Covered in full	80% of R&C after deductible	Covered in full	Covered in full	Covered in full
Second Surgical Opinion (Office Visit)	Covered in full	100% of R&C	Covered in full after $5 co-pay	Covered in full after $5 co-pay	Covered in full
Laboratory/X-Ray	Covered in full	80% of R&C after deductible	Covered in full after $5 co-pay	Covered in full	Covered in full
Maternity (Initial Visit To Determine Pregnancy)	Covered in full after $10 co-pay	80% of R&C after deductible	Covered in full after $5 co-pay	Covered in full after $5 co-pay	Covered in full
(Subsequent Visits/Delivery)	Covered in full	80% of R&C after deductible	Covered in full	Covered in full	Covered in full
Prescription Medication (Retail)	$5 generic/$10 brand (up to 30-day supply)	80% of R&C after deductible	$5 generic/$10 brand formulary/ $25 brand non-formulary (up to 30-day supply)	$5/prescription (up to 30-day supply)	$5 generic/$10 brand (up to 30-day supply)
(Mail Order)	$10 generic/$20 brand (up to 90-day supply)	Use in-network benefit	$10 generic/$20 brand formulary/ $50 brand non-formulary (31 to 90-day supply)	$10 (up to 90-day supply)	$7.50 generic/$15 brand (up to 90-day supply)

This is a brief summary and thus is not an all-inclusive description of services. Only covered expenses are provided/reimbursed through the programs. (R&C = Reasonable & Customary) **1-1-2006**

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	In-Network	**Out-of-Network**			
Preventive Care (Routine Care For Children Including Immunizations)	Covered in full (to age 19)	80% of R&C after deductible (to age 19)	Covered in full (to age 19)	Covered in full (to age 17)	Covered in full (to age 19)
(Well Woman Exam)	Covered in full after $10 co-pay	80% of R&C after deductible	Covered in full after $5 co-pay	Covered in full after $5 co-pay	Covered in full
(Pap Test)	Covered in full	80% of R&C after deductible	Covered in full after $5 co-pay	Covered in full w/office visit co-pay	Covered in full
(Mammogram)	Covered in full	80% of R&C after deductible	Covered in full after $5 co-pay	Covered in full	Covered in full
(Physical Exam)	Covered in full after $10 co-pay	Not covered	Covered in full after $5 co-pay	Covered in full after $5 co-pay	Covered in full
(Routine Eye Exam)	Not covered	Not covered	Covered in full after $5 co-pay	Covered in full after $5 co-pay (1 exam/year)	Covered in full (for optometrist)
Mental Health Care					
(Inpatient)	Covered in full	Same as inpatient hospital	Covered in full (Max: 35 days/year)	Covered in full (Max: 30 days/year)	Covered in full (Max: 30 days/year)
(Outpatient)	Covered in full after $10 co-pay/ visit	80% of R&C after deductible	$25 co-pay/visit (Max: 20 visits/year)	$5 co-pay visits 1-3 $25 co-pay visits 4-20 (Max:20 visits/year)	$25 co-pay (Max: 20 visits/year)
Substance Abuse Treatment					
(Inpatient Detox)	Covered in full	Same as inpatient hospital	Covered in full	Covered in full (Max: 3 periods/year)	Covered in full (Max: 7 days/year)
(Outpatient Rehab)	Covered in full after $10 co-pay/ visit	80% of R&C after deductible	$5 co-pay/visit (Max: 60 visits/year)	$5 co-pay/visit (Max: 60 visits/year)	$25 co-pay (Max: 60 visits/year)
Alternate Care					
(Home Health Care)	Covered in full (Max: 40 visits/year combined in and out of network)	80% of R&C after deductible	Covered in full	Covered in full (Max: 40 visits/year)	Covered in full (Max: 200 visits/year)
(Skilled Nursing Facility)	Covered in full (Max: 60 days/year combined in and out of network)	80% of R&C after deductible	Covered in full	Covered in full (Max: 45 days/year)	Covered in full
(Outpatient Short-Term Rehab: Physical Therapy)	Covered in full after $10 co-pay	80% of R&C after deductible	$5 co-pay (Max: 60 consecutive days/injury/lifetime)	$5 co-pay (Max: 60 consecutive days/injury/lifetime)	Covered in full (Max: 90 visits/year)
Durable Medical Equipment	Covered in full	80% of R&C after deductible	Not covered	Covered in full	Covered in full
External Prosthetic Devices	Covered in full	80% of R&C after deductible	Covered in full for initial device only	Covered in full	Covered in full
Hearing Aids	Covered in full ----------(Max: $1000/hearing aid/ear/3yrs)----------	80% of R&C after deductible	Not covered	Not covered	Not covered

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